(4) PLAN REFERENCE.—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) CATASTROPHIC PLAN.—

(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

(ii) coverage for at least three primary care visits.

(2) INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

(3) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

42 USC 18023.

SEC. 1303. SPECIAL RULES.

(a) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

(1) VOLUNTARY CHOICE OF COVERAGE OF ABORTION SERVICES.—

(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title), and subject to subparagraphs (C) and (D)—

(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

(ii) the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year. Determination.

(B) ABORTION SERVICES.—

(i) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(C) PROHIBITION ON FEDERAL FUNDS FOR ABORTION SERVICES IN COMMUNITY HEALTH INSURANCE OPTION.—

(i) DETERMINATION BY SECRETARY.—The Secretary may not determine, in accordance with subparagraph (A)(ii), that the community health insurance option established under section 1323 shall provide coverage of services described in subparagraph (B)(i) as part of benefits for the plan year unless the Secretary—

(I) assures compliance with the requirements of paragraph (2);

(II) assures, in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office, that no Federal funds are used for such coverage; and

(III) notwithstanding section 1323(e)(1)(C) or any other provision of this title, takes all necessary steps to assure that the United States does not bear the insurance risk for a community health insurance option's coverage of services described in subparagraph (B)(i).

(ii) STATE REQUIREMENT.—If a State requires, in addition to the essential health benefits required under section 1323(b)(3) (A), coverage of services described in subparagraph (B)(i) for enrollees of a community health insurance option offered in such State, the State shall assure that no funds flowing through or from the community health insurance option, and no other Federal funds, pay or defray the cost of providing coverage of services described in subparagraph (B)(i). The United States shall not bear the insurance risk for a State's required coverage of services described in subparagraph (B)(i).

(iii) EXCEPTIONS.—Nothing in this subparagraph shall apply to coverage of services described in subparagraph (B)(ii) by the community health insurance

option. Services described in subparagraph (B)(ii) shall be covered to the same extent as such services are covered under title XIX of the Social Security Act.

(D) ASSURED AVAILABILITY OF VARIED COVERAGE THROUGH EXCHANGES.—

(i) IN GENERAL.—The Secretary shall assure that with respect to qualified health plans offered in any Exchange established pursuant to this title—

(I) there is at least one such plan that provides coverage of services described in clauses (i) and (ii) of subparagraph (B); and

(II) there is at least one such plan that does not provide coverage of services described in subparagraph (B)(i).

(ii) SPECIAL RULES.—For purposes of clause (i)—

(I) a plan shall be treated as described in clause (i)(II) if the plan does not provide coverage of services described in either subparagraph (B)(i) or (B)(ii); and

(II) if a State has one Exchange covering more than 1 insurance market, the Secretary shall meet the requirements of clause (i) separately with respect to each such market.

(2) PROHIBITION ON THE USE OF FEDERAL FUNDS.—

(A) IN GENERAL.—If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

(i) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount (if any) of the advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

(ii) Any cost-sharing reduction under section 1402 of thePatient Protection and Affordable Care Act (and the amount (if any) of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

(B) SEGREGATION OF FUNDS.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall, out of amounts not described in subparagraph (A), segregate an amount equal to the actuarial amounts determined under subparagraph (C) for all enrollees from the amounts described in subparagraph (A).

Cost estimate.

(C) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.—

(i) IN GENERAL.—The Secretary shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a qualified health plan of the services described in paragraph (1)(B)(i).

(ii) CONSIDERATIONS.—In making such estimate, the Secretary—

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated

to result from such services, including prenatal care, delivery, or postnatal care;

(II) shall estimate such costs as if such coverage were included for the entire population covered; and

(III) may not estimate such a cost at less than $1 per enrollee, per month.

(3) PROVIDER CONSCIENCE PROTECTIONS.—No individual health care provider or health care facility may be discriminated against because of a willingness or an unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortions. Abortions.

(b) APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.—

(1) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(2) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—

(A) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(i) conscience protection;

(ii) willingness or refusal to provide abortion; and

(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

(c) APPLICATION OF EMERGENCY SERVICES LAWS.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as "EMTALA").

SEC. 1304. RELATED DEFINITIONS. 42 USC 18024.

(a) DEFINITIONS RELATING TO MARKETS.—In this title:

(1) GROUP MARKET.—The term "group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

(2) INDIVIDUAL MARKET.—The term "individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(3) LARGE AND SMALL GROUP MARKETS.—The terms "large group market" and "small group market" mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection

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Abortion Funding in the New Health Care Reform Act

Congress and the public agree that the federal government should not fund elective abortions. For over three decades this policy has been reflected in the Hyde amendment to the Labor/HHS appropriations bill and many similar laws. In key respects the newly enacted "Patient Protection and Affordable Care Act" (henceforth "the Act") does not follow this longstanding policy:

- **Federal funds in the Act can be used for elective abortions.** For example, the Act authorizes *and appropriates* $7 billion over five years (increased to $9.5 billion by the Health Care and Education Reconciliation Act of 2010) for services at Community Health Centers. These funds are not covered by the Hyde amendment (as they are not appropriated through the Labor/HHS appropriations bill governed by that amendment), or by the Act's own abortion limitation in Sec. 1303 (as that provision relates only to tax credits or cost-sharing reductions for qualified health plans, and does not govern all funds in the bill). So the funds can be used directly for elective abortions.

- **The Act uses federal funds to subsidize health plans that cover abortions.** Sec. 1303 limits only the direct use of a federal tax credit specifically to fund abortion coverage; it tries to segregate funds *within* health plans, to keep federal funds distinct from funds directly used for abortions. But the credits are still used to pay overall premiums for health plans covering elective abortions. This violates the policy of current federal laws on abortion funding, including the Hyde amendment, which forbid use of federal funds for any part of a health benefits package that covers elective abortions. By subsidizing plans that cover abortion, the federal government will expand abortion coverage and make abortions more accessible.

- **The Act uses federal power to force Americans to pay for other people's abortions even if they are morally opposed.** The Act mandates that insurance companies deciding to cover elective abortions in a health plan "*shall*... collect from *each enrollee* in the plan (without regard to the enrollee's age, sex, or family status) a separate payment" for such abortions. While the Act says that one plan in each exchange will not cover elective abortions, every other plan may cover them -- and everyone purchasing those plans, because they best meet his or her family's needs, will be required by federal law to fund abortions. No accommodation is permitted for people morally opposed to abortion. This creates a more overt threat to conscience than insurers engage in now, because in many plans receiving federal subsidies everyone will have to make separate payments solely and specifically for other people's abortions. Saying that this payment is not a "tax dollar" is no help if it is required by government.

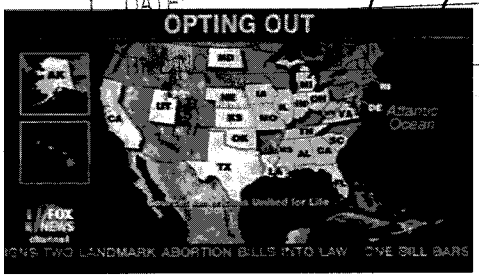
- **The solution is to follow current law.** The Stupak/Pitts provision in the House-passed health bill (also offered but rejected in the Senate as the Nelson/Hatch/Casey amendment) would have solved these problems by following longstanding current laws such as the Hyde amendment: No funds authorized or appropriated in the entire bill may be used for elective abortions or health plans that cover them. People would not be forced to pay for other people's abortions, and those who want abortion coverage could buy it separately without using federal funds. Legislation to maintain this longstanding federal precedent is still needed, to ensure that health care reform will truly expand life-affirming health care and not abortion.

(For more in-depth analysis of the Act on these issues, and of President Obama's executive order issued after its enactment, see www.usccb.org/healthcare/03-25-10Memo-re-Executive-Order-Final.pdf.)

4/12/10

States Opt Out

April 9, 2010



Following the passage of health care reform, signed by President Obama on March 23, 2010, AUL began implementing a strategy to respond to the anti-life provisions in the bill. The cornerstone of our response is the "Federal Abortion Mandate Opt-Out Act."

Background

The new health care reform law requires individual States to operate and maintain "health insurance exchanges." Health insurance plans offering abortion coverage *are* allowed to participate in a state's exchange and to receive federal subsidies unless the State legislature affirmatively opts-out of offering these plans. Individuals whose income falls between 150 and 400% of the federal poverty level receive tax credits to apply towards health insurance plans in the new exchanges. If one chooses a plan that covers abortion, his or her tax credit cannot be used to directly pay for abortions; however, the tax credit subsidizes the insurance plan which covers abortions.

Specific language in the new health care reform law (commonly referred to as the Nelson-Reid compromise) permits a state to opt-out of allowing insurance plans that cover abortions to participate in that state's exchanges.

Contrary to some perceptions, President Obama's March 24, 2010 Executive Order does not make the new health care reform law conform to the longstanding principle of the Hyde Amendment – that the federal government will not pay for abortions or for insurance plans that cover abortions.

While the text of the Executive Order *addresses* the health insurance exchanges, it utterly fails to *apply* the language of the Hyde Amendment to them. Section 2 of the Order provides guidelines for "strict compliance" with the provisions in the new law that address how federal subsidies are handled in plans that cover abortions in the exchanges. However, these guidelines do nothing to *prevent* federal subsidies from going to plans that cover abortions, and therefore fail to prevent the new law from directly violating the principles embodied in the Hyde Amendment and other federal law.

Additionally, even if the Executive Order were sufficient to address pro-life concerns, it is not permanent law. The order can be repealed by the Obama Administration or a future administration easily.

The Federal Abortion Mandate Opt-Out Act

To assist state legislators in opting-out of providing health insurance plans with abortion coverage through their exchanges, AUL has developed "The Federal Abortion Mandate Opt-Out Act."

Currently, more than thirty states have either introduced an opt-out bill, are planning to introduce a bill shortly, or are laying the groundwork to introduce a bill as soon as their legislative calendars permit. Those that have passed such legislation into law include Arizona, Louisiana, Mississippi, Missouri, and Tennessee.

Additional Limitations on Insurance

Some states, with our help, are going even farther than preventing insurance plans that cover abortions from participating in their state exchanges. One positive outcome from the 2009-2010 health care reform debate is that many more Americans are now aware that a large number of private insurance plans, even their own, cover elective abortions. In fact, according to the Guttmacher Institute, "87% of typical employer-based insurance policies in 2002 covered *medically necessary* or *appropriate* abortions."

As a result, many pro-life citizens and state legislators are now seeking a way to prohibit insurance coverage of elective abortions in their states. Currently, five states have laws, dating back as far as 1978, that prohibit private insurance plans operating within their states from covering elective abortions. To assist legislators from other states in prohibiting health insurance coverage of elective abortions within their states, AUL has developed "The Abortion Coverage Prohibition Act," which is modeled after existing state laws on the topic.

State legislators are also seeking to prohibit abortion coverage for state employees. Only fourteen states currently prohibit the use of state funds for abortion coverage (with no or limited exceptions) for state employees. To assist state legislators in prohibiting the use of state taxpayer funds to pay for health insurance coverage of elective abortions for state employees, AUL has developed "The Employee Coverage Prohibition Act," which is also modeled after existing state laws on the topic.

To order a copy of the AUL model bill "Federal Abortion Mandate Opt-Out Act" or other AUL model legislation, click here [1].

http://www.aul.org/initiative/opt-out/

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